Claims Clues

A Publication of the AHCCCS Claims Department June, 1999

Quarterly Provider Meetings Planned

The first in a series of quarterly Provider Information Meetings is tentatively scheduled for late August or early September.

The meetings, which will be held in Phoenix, Mesa, Tucson, and Flagstaff, are designed to provide a forum where AHCCCS can disseminate information to providers and or providers' staff and also to allow providers and or their staff to discuss issues with AHCCCS staff.

The quarterly meetings are an outcome of discussions during recent Focus Groups designed to help the AHCCCS Administration develop a comprehensive provider orientation and training program.

The tentative agenda for the first quarterly meetings includes the following topics:

1. Electronic Remittance Advice
2. Medicare crossover
3. Tax ID project
4. Outcome of Focus Group meetings
5. Topics suggested by providers
6. Question and answer session

Providers and/or their staff members who are interested in attending one of the meetings should complete the attached interest form and submit it to AHCCCS no later than July 20, 1999. The form includes a section where providers may suggest discussion topics. ❒

Providers Surveyed About Verification Process

The AHCCCS Administration is surveying providers to determine their satisfaction with the agency's eligibility and enrollment verification process.

The survey form and a postage-paid return envelope are being inserted in Remittance Advice packages over the next few weeks in an effort to reach as many providers as possible. Providers may receive more than one survey during this period. If an office receives a second survey, other office staff members who verify eligibility and enrollment are asked to complete the survey.

The survey asks providers to "bubble in" responses to 12 questions regarding the agency's eligibility and enrollment verification process. There also is space for providers to suggest improvements in the process.

AHCCCS currently employs four verification processes:

- The newest process uses "swipe card" technology to verify eligibility and enrollment. Plastic recipient ID cards feature a magnetically encoded strip that enables providers to "swipe" the card through a card reader, similar to using credit and debit cards in stores.
- The on-line Medical Eligibility Verification System (MEVS), also known as Medifax, allows providers to use a terminal or PC to verify eligibility and enrollment by inputting data about the recipient.
- The Interactive Voice Response system (IVR) allows unlimited verifications by entering information using a touch-tone phone and following the instructions. In Maricopa County only, providers can request faxed documentation of verifications.
- Operators in the AHCCCS Verification Unit are on duty 24 hours a day, 7 days a week to verify eligibility and enrollment for providers. ❒

Pharmaceutical Formulary Under Revision

The AHCCCS Administration is revising its current pharmaceutical formulary. The updates will include specific policies on coverage of drugs for each eligibility group, over-the-counter drugs, and drugs that will only be covered when prior authorization is obtained.

Providers will be advised of the progress of the formulary revisions in future issues of *Claims Clues*. ❒

Dialysis Facilities Must Bill Appropriate Codes

AHCCCS is currently revising the computer program that processes claims and calculates reimbursement for free-standing dialysis facility services.

Part of this process is the improvement of reimbursement logic to ensure that treatment and payment conform to Medicare requirements. Dialysis facilities should ensure that only Medicare-approved revenue codes are used on the UB-92 claim form. Revenue codes 001, 270, 304, 320, 38X, 390, 634, 635, 636, 730, 771, 821, 841, 851, and 922 are the only codes allowed on AHCCCS-primary dialysis facility claims.

Medicare has also liberalized regulations defining how dialysis services can be provided to patients confined to a skilled nursing facility.

AHCCCS is evaluating the new regulations in relation to AHCCCS' prior authorization requirements and reimbursement procedures. Changes will be announced in future issues of *Claims Clues*. ❒

Medicare Recovery Program Starts New Cycle

Public Consulting Group, Inc. (PCG), the AHCCCS TPL contractor, recently implemented Cycle 8 of the Medicare Disallowance Recovery Program. Cycle 8 covers the period between October 1, 1997 and March 31, 1999.

This review identified Medicare coverage for a number of AHCCCS fee-for-service recipients for whom providers received reimbursement from AHCCCS. Letters will be sent to all providers by June 30 identifying the recipients and asking the providers, in accordance with Federal regulations, to bill Medicare for those claims if they have not already done so. Copies of EOMBs or other acceptable documentation containing payments and denials on these specific claims must be forwarded to PCG.

Providers have 120 days from the date of the letter to bill Medicare or forward documentation of Medicare denials to PCG. If copies are not received by PCG within that time period, AHCCCS will automatically recoup the full amount of the original AHCCCS payment.

Providers should direct questions and correspondence to:

Christopher Connor
PCG Inc.
345 Magnolia Drive
Suite A-16
Tallahassee, FL 32301

Providers should not contact the AHCCCS Administration. ❒

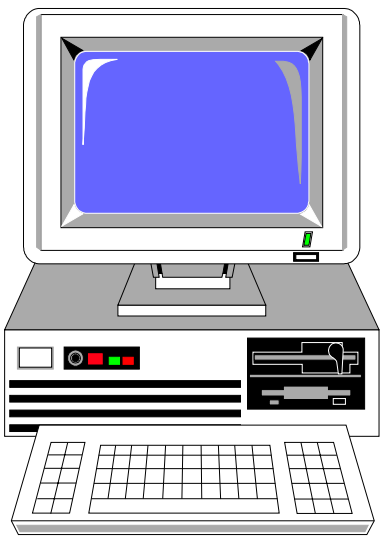
Electronic Remittance Available Soon

The AHCCCS Administration anticipates making the Fee-for-Service Remittance Advice available to providers in an electronic format by late summer.

The Remittance Advice will be transmitted to providers via the Internet to the provider's electronic mail (email) address. The Remittance Advice will be a file attachment to an email, and it will retain its current content. Providers will be informed of file specifications at a later date.

Electronic transmission of the Remittance Advice does **not** include electronic deposit of reimbursement checks. Reimbursement checks will continue to be mailed to the provider's pay-to address.

Providers must authorize the electronic Remittance Advice transmission in writing. The authorization form, which is being developed, must be signed by the provider or the provider's designated agent.



Providers who opt for the electronic Remittance Advice will no longer receive a paper copy of the document.

Future issues of *Claims Clues* will provide more details about the electronic Remittance Advice as well as a copy of the authorization form.

The AHCCCS Administration anticipates making the electronic Remittance Advice available to providers by August 1. ❒

Physicians Limited in Billing Pathology Codes

In accordance with Medicare guidelines, physicians may bill only a limited number of CPT codes for pathology services performed in a hospital setting.

AHCCCS follows Medicare guidelines and will only pay physicians and other individual practitioners for the medical interpretation of a pathology test performed at a hospital. AHCCCS does not reimburse physicians for the technical portion of tests performed at hospitals or for any indirect costs, such as supervising the laboratory.

The hospital is reimbursed for the technical component of the test performed in its facility. The hospital is also responsible for compensating employees that may be supervising the lab.

Physicians and other individual practitioners will be reimbursed only for the pathology codes (and modifiers where appropriate) listed below when the place of service code is 21 (I/P hospital), 22 (O/P hospital), or 23 (Emergency room – hospital). ❐

CPT Code	Modifier	Description	CPT Code	Modifier	Description
80500		Path consultation, limited	88269	26	Chromosome analysis, in situ
80502		Path consultation, comprehensive	88271	26	Molecular cytogenetics, DNA probe
83020	26	Hemoglobin electrophoresis	88272	26	Molecular cytogenetics, 3-5 cells
83912	26	Molecular diagnostics	88273	26	Molecular cytogenetics, 10-30 cells
84165	26	Protein, electrophoretic fractionation	88274	26	Molecular cytogenetics, 25-99 cells
85060		Blood smear, interpretation	88275	26	Molecular cytogenetics, 100-300 cells
85095		Bone marrow aspiration	88280	26	Chromosome analysis, add'l karyo
85097		Bone marrow interpretation	88283	26	Chromosome analysis, band tech
85102		Bone marrow biopsy	88285	26	Chromosome analysis, add'l cells
85390	26	Fibrinolysins screen	88289	26	Chromosome analysis, add'l high res
85576	26	Platelet aggregation	88291		Cyto/molecular cytogenetics
86077		Blood bank physician service	88299	26	Unlisted cytogenic study
86078		Blood bank physician service	88300	26	Pathology, Level I
86079		Blood bank physician service	88302	26	Pathology, Level II
86255	26	Fluorescent antibody, screen	88304	26	Pathology, Level III
86256	26	Fluorescent antibody, titer	88305	26	Pathology, Level IV
86320	26	Immunoelectrophoresis, serum	88307	26	Pathology, Level V
86325	26	Immunoelectrophoresis, other	88309	26	Pathology, Level VI
86327	26	Immunoelectrophoresis, crossed	88311	26	Decalcification
86334	26	Immunofixation electrophoresis	88312	26	Special Stains, Group I
87164	26	Dark field examination	88313	26	Special Stains, Group II
87207	26	Smear, special stain	88314	26	Histochemical staining
88104	26	Cytopathology	88318	26	Determinative histochemistry
88106	26	Cytopathology	88319	26	Determinative histochemistry
88107	26	Cytopathology	88321		Consultation, slides
88108	26	Cytopathology	88323	26	Consultation and report
88125	26	Cytopathology	88325		Consultation, comprehensive
88141		Cytopathology	88329		Consultation, surgery
88160	26	Cytopathology	88331	26	Consultation, surgery, frozen section
88161	26	Cytopathology	88332	26	Consult, surgery, frozen, each add'l
88162	26	Cytopathology	88342	26	Immunocytochemistry
88170	26	Fine needle aspiration	88346	26	Immunofluorescent study, direct
88171	26	Fine needle aspiration	88347	26	Immunofluorescent study, indirect
88172	26	Evaluation of aspirate	88348	26	Electron microscopy, diagnostic
88173	26	Evaluation, interpretation and report	88349	26	Electron microscopy, scanning
88180	26	Flow cytometry	88355	26	Morphometric analysis, skeletal
88182	26	Flow cytometry	88356	26	Morphometric analysis, nerve
88199	26	Unlisted cytopathology	88358	26	Morphometric analysis, tumor
88230	26	Tissue Culture, lymphocyte	88362	26	Nerve teasing preparations
88233	26	Tissue Culture, skin	88365	26	Tissue in situ hybridization
88235	26	Tissue Culture, amniotic fluid	88399	26	Unlisted surgical pathology
88237	26	Tissue Culture, bone marrow	89060	26	Crystal identification
88239	26	Tissue Culture, solid tumor	89100		Duodenal aspiration, single specimen
88245	26	Chromosome analysis	89105		Duodenal aspiration, multiple specimen
88248	26	Chromosome analysis	89130		Gastric aspiration, each
88249	26	Chromosome analysis	89132		Gastric aspiration after stimulation
88261	26	Chromosome analysis,	89135		Gastric aspiration, one hour
88262	26	Chromosome analysis	89136		Gastric aspiration, two hours
88263	26	Chromosome analysis	89140		Gastric aspiration, two hours
88264	26	Chromosome analysis	89141		Gastric aspiration, three hours
88267	26	Chromosome analysis	89399	26	Unlisted misc pathology

Oxygen Equipment Reimbursement Revised

AHCCCS has revised its policy on oxygen equipment to conform to Medicare's policy on reimbursement of these codes.

According to Medicare, certain oxygen rental rates represent a monthly allowance per beneficiary. Any claim for these oxygen services should be billed with one unit for a calendar month.

Reimbursement of the single unit represents the entire month's rental regardless of the actual number of days that services are provided.

Accordingly, the AHCCCS capped fee for the oxygen equipment codes listed below have been changed to a monthly rental rate.

An evaluation of provider claims with dates of service on and after April 1, 1999 has been completed. Claims where reimbursement of the rental was calculated at a prorated amount will be reprocessed in the AHCCCS Claims System, and additional payment will be issued when appropriate. Providers should *not* resubmit these claims.

One procedure code; E0935, is a *daily* rate, and the rate has been recalculated. The new rental rate reimbursement of this code is $18.43 per day. When billing this code, one unit equals one day.

Code	Monthly Rental Rate	Code	Monthly Rental Rate	Code	Monthly Rental Rate
E0424	$194.40	E1400	$194.40	E1404	$194.40
E0431	$36.00	E1401	$194.40	E1405	$222.90
E0434	$36.00	E1402	$194.40	E1406	$211.80
E0439	$194.40	E1403	$194.40		

Provider File Changes Require Authorized Signature

All requests to change provider information on file at AHCCCS must be submitted in writing on the provider's letterhead and signed by the provider or the provider's authorized agent.

The name of the authorized signer must be on file with the AHCCCS Provider Registration Unit. Change requests submitted by someone not authorized by the provider cannot be accepted.

Changes that must be reported include, but are not limited to, changes affecting licensure/certification, change of address (correspondence, service, and/or pay-to), name changes, change of group billing arrangements, and change of ownership.

Failure to report changes to information on file may result in misdirected payments and correspondence, termination of provider status, and/or recoupment of payment. ❒

Packet Offers Information on Electronic Claims

The AHCCCS Electronic Claims Submission (ECS) Unit has prepared an information packet to assist providers who want to submit claims electronically to the AHCCCS Administration.

The package contains information on record layout, testing requirements, and other aspects of the electronic claims submission process. Providers may obtain an information packet by contacting the ECS Unit at (602) 417-4242 or (602) 417-4706.

AHCCCS accepts HCFA 1500 and UB-92 claims submitted electronically. Providers may submit claims directly to AHCCCS or use a clearinghouse that submits claims on behalf of many providers.

Providers who use a clearinghouse must still meet the 9- and 12-month claim submission time frames. There is no charge for claims submitted directly to AHCCCS. Clearinghouses may charge for their services.

Claims must be submitted between 6:00 a.m. and 6:00 p.m. Monday through Friday. All completed transmissions will be loaded into the AHCCCS system that day. However, if a transmission is not completed by 6:00 p.m., it will not be accepted. ❒

Quarterly Provider Meetings

The AHCCCS Administration will conduct its first quarterly provider meeting in late August or early September. The meetings, which will be held in Phoenix, Mesa, Tucson, and Flagstaff, are designed to provide a forum whereby AHCCCS can disseminate information to providers and also to allow providers to discuss issues with AHCCCS staff. It is anticipated that these meetings will last 2 to 2½ hours.

The tentative agenda for the first meeting includes the following topics:

- Electronic Remittance Advice
- Medicare crossover
- Topics suggested by providers
- Outcome of Focus Group meetings
- Tax ID project
- Question and answer session

If you are interested in participating in one of these meeting, please complete the form below and fax it to the AHCCCS Claims Policy/Training Unit at (602) 256-1474. You also may mail this form to:

AHCCCS Claims Policy/Training Unit
701 E. Jefferson Street, MD 8100
Phoenix, AZ 85034

Please return this form no later than July 20, 1999. Thank you.

Provider Name: _____ AHCCCS Provider ID: _____

Provider Type:
(e.g., physician, hospital, emergency transportation, etc.) _____ Specialty: (Physicians only) _____

Street Address or P.O. Box: _____

City: _____ State: _____ ZIP: _____

Contact Person: _____ Telephone: ( ) _____

FAX: ( ) _____

Suggested topics: _____

_____

_____

I would prefer to attend a focus group in (Please select one):

Phoenix ☐ Mesa ☐ Tucson ☐ Flagstaff ☐